FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032862

Facility Name: DANVILLE CARE CENTER

Address: 1701 NORTH BOWMAN AVE (Number) DANVILLE (City) 61832 (Zip Code)

County: VERMILLION

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-3532095

Date of Initial License for Current Owners: 10/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) BRADLEY ALTER

(Title) SECRETARY

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	82	Intermediate/DD	82	29,930	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,171		3,555	5,726	8
9	SNF/PED					9
10	ICF	33,078	3,049	1,102	37,229	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,249	3,049	4,657	42,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.84%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,555

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	199,059	24,410	10,725	234,194		234,194		234,194			1
2	Food Purchase		199,656		199,656		199,656	(794)	198,862			2
3	Housekeeping	168,259	34,315		202,574		202,574		202,574			3
4	Laundry	85,357	34,277	2,615	122,249		122,249		122,249			4
5	Heat and Other Utilities			163,905	163,905		163,905	872	164,777			5
6	Maintenance	66,290	36,349	20,132	122,771		122,771	570	123,341			6
7	Other (specify):*			9,171	9,171		9,171		9,171			7
8	**TOTAL General Services**	518,965	329,007	206,548	1,054,520		1,054,520	648	1,055,168			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,319,321	105,512	136,003	1,560,836		1,560,836	35,868	1,596,704			10
10a	Therapy	77,821	403	268	78,492		78,492		78,492			10a
11	Activities	49,970	1,771	3,439	55,180		55,180		55,180			11
12	Social Services	83,107		3,020	86,127		86,127		86,127			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,530,219	107,686	142,730	1,780,635		1,780,635	35,868	1,816,503			16
	C. General Administration											
17	Administrative	81,732		62,904	144,636		144,636	(13,266)	131,370			17
18	Directors Fees											18
19	Professional Services			99,143	99,143		99,143	(58,717)	40,426			19
20	Dues, Fees, Subscriptions & Promotions			23,086	23,086		23,086	(9,017)	14,069			20
21	Clerical & General Office Expenses	91,745	16,288	228,325	336,358		336,358	(56,134)	280,224			21
22	Employee Benefits & Payroll Taxes			471,742	471,742		471,742	17,839	489,581			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,636	2,636		2,636	12,325	14,961			24
25	Other Admin. Staff Transportation			9,170	9,170		9,170	11,291	20,461			25
26	Insurance-Prop.Liab.Malpractice			165,021	165,021		165,021	18,982	184,003			26
27	Other (specify):* marketing	28,680			28,680		28,680	(28,680)				27
28	**TOTAL General Administration**	202,157	16,288	1,062,027	1,280,472		1,280,472	(105,377)	1,175,095			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,251,341	452,981	1,411,305	4,115,627		4,115,627	(68,861)	4,046,766			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: DANVILLE CARE CENTER **#0032862** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	10,725	
	REPAIRS & MAINTENANCE		0	
			0	10,725
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,615	
			0	2,615
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,298	
	ELECTRICITY		73,177	
	WATER		54,430	
	CABLE TV - LOBBY		0	
			0	163,905
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,940	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,462	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,040	
	FIRE SERVICE		1,690	
			0	
			0	
			0	20,132
7	**OTHER**			
	SCAVENGER		9,171	
	SECURITY SERVICE		0	9,171
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	124,598	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		9,250	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	400	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,755	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	136,003
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	14	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	9	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	245	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	268
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		1,341	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,098	
			0	3,439
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,020	
			0	3,020
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number DANVILLE CARE CENTER #0032862 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	62,904	62,904
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,619	
	ADMINISTRATIVE CONSULTANTS	XIX C	47,748	
	PROFESSIONAL FEES	XIX C	42,776	
			0	99,143
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,192	
	EMPLOYEE WANT ADS	XIX F	10,631	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	67	
	LICENSES & PERMITS	XIX F	3,286	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	2,910	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,086
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		1,897	
	OUTSIDE CLERICAL SERVICES		191,196	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,133	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		126	
	TELEPHONE		16,281	
	MESSENGER SERVICE-postage		7,692	
			0	228,325

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	170,429	
	UNEMPLOYMENT COMPENSATION	XIX D	110,935	
	WORKERS COMPENSATION INSURANCI	XIX D	129,447	
	HOSPITALIZATION INSURANCE	XIX D	55,482	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,617	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,832	
	CHICAGO HEAD TAX	XIX D	0	471,742
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,988	
	TRAVEL	XIX G	648	
			0	
			0	2,636
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,170	9,170
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		165,021	165,021
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,411,305

DANVILLE CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	199,656	PATIENT MEALS	128865
LESS SALES TAX	(794)	ADD EMPLOYEE MEALS	0
NET FOOD	198,862	TOTAL MEALS/YEAR	128865
TOTAL PATIENT CENSUS	42,955	NET FOOD	198862
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	128865
TOTAL PATIENT MEALS	128865	COST PER MEAL	1.54
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number DANVILLE CARE CENTER #0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			60,892	60,892		60,892	198,242	259,134			30
31	Amortization of Pre-Op. & Org.							26,667	26,667			31
32	Interest			47,430	47,430		47,430	490,233	537,663			32
33	Real Estate Taxes			136,125	136,125		136,125		136,125			33
34	Rent-Facility & Grounds			549,669	549,669		549,669	(543,402)	6,267			34
35	Rent-Equipment & Vehicles			20,804	20,804		20,804		20,804			35
36	Other (specify):*											36
37	TOTAL Ownership			814,920	814,920		814,920	171,740	986,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,679	103,194	251,873		251,873		251,873			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		148,679	212,694	361,373		361,373		361,373			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,251,341	601,660	2,438,919	5,291,920		5,291,920	102,879	5,394,799			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	28,799	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(794)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,133)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,192)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,910)	20		28
29	Other-Attach Schedule	(45,490)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,720)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	140,599		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 140,599		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 102,879		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

DANVILLE CARE CENTER

ID# 0032862

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	LEGAL FEES	(16,810)	19	2
3	MARKETING	(28,680)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(45,490)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(794)	0	0	0	0	0	0	0	0	0	0	(794)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	872	0	0	0	0	0	0	0	0	872	5
6	Maintenance	0	0	570	0	0	0	0	0	0	0	0	570	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(794)	0	1,442	0	0	0	0	0	0	0	0	648	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	35,868	0	0	0	0	0	0	0	0	35,868	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	35,868	0	0	0	0	0	0	0	0	35,868	16
	C. General Administration													
17	Administrative	0	(62,904)	49,638	0	0	0	0	0	0	0	0	(13,266)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(16,810)	(47,748)	5,841	0	0	0	0	0	0	0	0	(58,717)	19
20	Fees, Subscriptions & Promotions	(9,102)	0	85	0	0	0	0	0	0	0	0	(9,017)	20
21	Clerical & General Office Expenses	(11,133)	(187,618)	142,617	0	0	0	0	0	0	0	0	(56,134)	21
22	Employee Benefits & Payroll Taxes	0	0	17,839	0	0	0	0	0	0	0	0	17,839	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	12,325	0	0	0	0	0	0	0	0	12,325	24
25	Other Admin. Staff Transportation	0	0	11,291	0	0	0	0	0	0	0	0	11,291	25
26	Insurance-Prop.Liab.Malpractice	0	0	18,982	0	0	0	0	0	0	0	0	18,982	26
27	Other (specify):*	(28,680)	0	0	0	0	0	0	0	0	0	0	(28,680)	27
28	**TOTAL General Administration**	(65,725)	(298,270)	258,618	0	0	0	0	0	0	0	0	(105,377)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(66,519)	(298,270)	295,928	0	0	0	0	0	0	0	0	(68,861)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	28,799	166,061	3,382	0	0	0	0	0	0	0	0	198,242	30
31	Amortization of Pre-Op. & Org.	0	26,667	0	0	0	0	0	0	0	0	0	26,667	31
32	Interest	0	490,233	0	0	0	0	0	0	0	0	0	490,233	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(549,669)	6,267	0	0	0	0	0	0	0	0	(543,402)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	28,799	133,292	9,649	0	0	0	0	0	0	0	0	171,740	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(37,720)	(164,978)	305,577	0	0	0	0	0	0	0	0	102,879	45

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SEE ATTACHED SCHEDULE		CERTIFIED HEALTH	SKOKIE	BKKPG/MGMT
RITA L. GELLER	38.04			MANAGEMENT		
JOSEPH C. CHOW	39.13					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 62,904	CERTIFIED HEALTH MANAGEMENT		$	$ (62,904)	1
2	V	21	BOOKKEEPING	191,196				(191,196)	2
3	V	19	ADMIN CONSULTING FEES	47,748				(47,748)	3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	549,669	DANVILL CARE CENTER LLC			(549,669)	7
8	V	21	OFFICE EXPENSE				3,578	3,578	8
9	V	30	DEPRECIATION				166,061	166,061	9
10	V	31	AMORTIZATION				26,667	26,667	10
11	V	32	INTEREST				490,233	490,233	11
12	V								12
13	V								13
14	Total			$ 851,517			$ 686,539	$ * (164,978)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 0	$	15
16	V	5	ELECTRIC/GAS		" " "		872	872	16
17	V	6	MAINTENANCE		" " "		570	570	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		35,868	35,868	18
19	V	17	ADMIN SALARIES		" " "		49,638	49,638	19
20	V	19	PROFESSIONAL FEES		" " "		5,841	5,841	20
21	V	20	FEES, SUBSCRIPTION		" " "		85	85	21
22	V	21	OFFICE EXP		" " "		142,617	142,617	22
23	V	22	EMPLOYEE BENEFITS		" " "		17,839	17,839	23
24	V	24	TRAVEL.SEMINAR		" " "		12,325	12,325	24
25	V	25	TRANSPORTATION		" " "		11,291	11,291	25
26	V	26	INSURANCE		" " "		18,982	18,982	26
27	V	30	DEPRECIATION		" " "		3,382	3,382	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		6,267	6,267	29
30	V	35	EQUIPMENT RENTAL		" " "		0		30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 305,577	$ * 305,577	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 52,694	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,694		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	246,749	8	$ 0	$	42,955	$ 0	1
2	5	ELECTRIC & GAS	" " "	246,749	8	5,007		42,955	872	2
3	6	MAINTENANCE	" " "	246,749	8	3,275		42,955	570	3
4	10	NURSING/MEDICAL RECORDS	" " "	246,749	8	206,038	206,038	42,955	35,868	4
5	17	ADMIN SALARIES	" " "	246,749	8	285,136	285,136	42,955	49,638	5
6	19	PROFESSIONAL FEES	" " "	246,749	8	33,552		42,955	5,841	6
7	20	FEE, SUBSCRIPTIONS	" " "	246,749	8	490		42,955	85	7
8	21	OFFICE EXP.	" " "	246,749	8	819,245	705,623	42,955	142,617	8
9	22	EMPLOYEE BENEFITS	" " "	246,749	8	102,474		42,955	17,839	9
10	24	TRAVEL/SEMINAR	" " "	246,749	8	70,798		42,955	12,325	10
11	25	TRANSPORTATION	" " "	246,749	8	64,859		42,955	11,291	11
12	26	INSURANCE	" " "	246,749	8	109,041		42,955	18,982	12
13	30	DEPRECIATION	" " "	246,749	8	19,425		42,955	3,382	13
14	32	INTEREST	" " "	246,749	8	0		42,955	0	14
15	34	OFFICE RENT	" " "	246,749	8	36,000		42,955	6,267	15
16	35	EQUIPMENT RENTAL	" " "	246,749	8	0		42,955	0	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,755,340	$ 1,196,797		$ 305,577	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DANVILLE CARE CENTER LLC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 166,061	$	1	$ 166,061	1
2	31	AMORTIZATION		1	1	26,667		1	26,667	2
3	32	INTEREST		1	1	490,233		1	490,233	3
4	21	OFFICE EXP		1	1	3,578		1	3,578	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 686,539	$		$ 686,539	25

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				614,985		PRIME+	38,244	6
7	BANK FINANCIAL		X					100,000		PRIME+	6,748	7
8	SHAREHOLDER LN	X		WORKING CAPITAL				175,000		PRIME+	2,438	8
9	TOTAL Facility Related						$	$ 889,985			$ 47,430	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 889,985			$ 47,430	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number DANVILLE CARE CENTER **#** 0032862 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 61,695	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 65,072	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,377	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,374	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 66,374	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 136,125	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	57,848	8
	2001	59,372	9
	2002	60,866	10
	2003	60,485	11
	2004	65,072	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME DANVILLE CARE CENTER COUNTY VERMILLION

FACILITY IDPH LICENSE NUMBER 0032862

CONTACT PERSON REGARDING THIS REPORT DON FIETS

TELEPHONE (847) 674-4700 FAX #: (847) 674-4733

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-34-100-005-060	NURSING HOME	$ 25,978.00	$ 25,978.00
2.	18-33-200-016-0060		$ 39,094.00	$ 39,094.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 65,072.00	$ 65,072.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 350,000	1
2					2
3	TOTALS			$ 350,000	3

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1998		$ 2,954,225	$ 152,666		$ 152,666	$	$ 1,221,334	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1989	34,167	1,085	30	1,139	54	17,928	9
10	LEASEHOLD IMPROVEMENTS			1990	17,344	551	30	578	27	8,756	10
11	LEASEHOLD IMPROVEMENTS			1991	45,376	1,441	30	1,513	72	21,470	11
12	LEASEHOLD IMPROVEMENTS			1992	12,043	382	30	401	19	5,309	12
13	LEASEHOLD IMPROVEMENTS			1993	9,213	236	30	307	71	3,528	13
14	LEASEHOLD IMPROVEMENTS			1994	8,304	213	39	213	(0)	2,459	14
15	NURSING STATION			1995	14,331	367	39	367	0	3,778	15
16	DOOR/LIGHT FIXTURES			1995	17,592	451	39	451	0	4,641	16
17	FIRE ALARM & ELECTRICAL WORK			1995	2,420	62	39	62	0	638	17
18	SHOWER/BATH CONST.			1995	4,704	121	39	121	(0)	1,245	18
19	NURSECALL REPAIR			1996	1,655	42	39	42	0	424	19
20	SMOKE DETECTORS/LIGHT FIXTURES/DOOR			1996	5,894	151	39	151	0	1,476	20
21	RESURFACE PARKING AREA			1996	12,910	861	15	861	(0)	8,169	21
22	ROOF REPAIR			1966	12,742	327	39	327	(0)	2,984	22
23	WARDROBE UNITS			1996	8,361	214	39	214	0	1,935	23
24	FLOORING			1996	2,444	63	39	63	(0)	569	24
25	CARPET/WALLPAPER/BUMPER GUARDS/COVE BASE			1997	19,014	488	39	488	(0)	4,186	25
26	PARKING LOT REPAIR			1997	1,500	100	15	100		850	26
27	PAVILION CONST.			1997	8,297	213	39	213	(0)	1,844	27
28	THERAPY ROOM ADDITION			1998	320,230	8,211	39	8,211	0	57,820	28
29	NORTH WING RENOVATION			1998	65,143	1,670	39	1,670	0	11,760	29
30	BUMPER GUARDS			1998	9,285	238	39	238	0	1,895	30
31	CEILING REPAIR/DRYWALL/TILE			1999	17,083	438	39	438	0	2,670	31
32	NURSE CALL/FIRE ALARM SYSTEM			1999	5,616	144	39	144		944	32
33	ROOF REPAIR/AIR EXHAUSTS			1999	7,095	182	39	182	(0)	1,196	33
34	LANDSCAPING			1999	12,535	836	15	836	(0)	5,433	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR CONDITIONER	2000	$ 3,436	$ 491	7	$ 491	$ (0)	$ 2,232	37
38	CARPET/COVE BASE/WALLPAPER	2000	9,734	1,391	7	1,391	(0)	6,294	38
39	BATHROOM REPAIR/REMODEL	2000	11,104	404	27.5	404	(0)	2,330	39
40	HOT TUB ROOM REPAIR/REMODEL	2000	6,700	244	27.5	244	(0)	1,402	40
41	ALARMA SYSTEM/DOORS/CAMERAS	2000	15,171	552	27.5	552	(0)	3,178	41
42	NORTH WING RENOVATION	2000	4,809	175	27.5	175	(0)	1,003	42
43	WATER HEATER VALVE	2000	1,026	37	27.5	37	0	217	43
44	SECURITY DOOR	2001	693	25	27.5	25	0	112	44
45	WATER HEATER	2001	684	25	27.5	25	(0)	111	45
46	ROOF REPAIRS	2002	10,000	364	27.5	364	(0)	1,137	46
47	CONCRETE REPAIRS	2002	1,592	58	27.5	58	(0)	182	47
48	ROOF	2003	23,000	836	27.5	836	0	2,055	48
49	BEDROOM CEILING/WALLS	2003	3,300	120	27.5	120		295	49
50	BLINDS	2003	3,118	599	5	624	25	1,872	50
51	VENT TO ROOF	2003	5,700	207	27.5	207	0	509	51
52	INSTALL PULL STATIONS	2003	1,033	38	27.5	38	(0)	93	52
53	ELECTRIC DOOR HOLDER/CLOSER	2003	852	31	27.5	31	(0)	76	53
54	GAS/ELECT ROOF TOP UNIT	2003	6,542	238	27.5	238	(0)	585	54
55	WATER HEATER REPAIR	2003	1,971	72	27.5	72	(0)	177	55
56	REPLACE DOORS/EXIT DEVICES	2003	13,040	474	27.5	474	0	1,165	56
57	NURSE CALL SYSTEM	2003	9,000	327	27.5	327	0	804	57
58	HEAT/COOL ROOF TOP UNIT	2003	5,287	192	27.5	192	0	472	58
59	DURO LAST ROOFING SYSTEM	2003	41,750	1,518	27.5	1,518	0	3,732	59
60	REPAIR CEILING/DOORS	2003	8,000	291	27.5	291	(0)	715	60
61	NURSE CALL SYSTEM/PULL STATIONS	2004	7,368	268	27.5	268	(0)	402	61
62	CEILING PANEL REPLACEMENT	2004	999	36	27.5	36	0	54	62
63	HANDRAILS	2004	1,406	51	27.5	51	0	77	63
64	SKYLITE	2004	2,400	87	27.5	87	0	131	64
65	WALL A/C UNITS	2004	10,249	373	27.5	373	(0)	559	65
66	ALARM SYSTEM	2004	1,995	73	27.5	73	(0)	109	66
67	WALLPAPER/PAINTING/COVE REPLACEMENT	2004	26,302	956	27.5	956	0	1,434	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,867,784	$ 182,306		$ 182,572	$ 266	$ 1,428,753	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,867,784	$ 182,306		$ 182,572	$ 266	$ 1,428,753	1
2	WALL AC UNITS/WALLPAPERING	2005	27,054	5,411	5	2,705	(2,706)	2,705	2
3	SHEET VINYL BATHROOM/ROTUNDA	2005	5,456	173	27.5	99	(74)	99	3
4	ROOF REPLACEMENT-PARTIAL	2005	29,083	573	27.5	529	(44)	529	4
5	HANDRAILS IN HALLWAYS	2005	15,871	361	27.5	289	(72)	289	5
6	REMOVE OLD/INSTALL NEW CERAMIC TILE	2005	9,460	100	27.5	172	72	172	6
7	BACKFLOW PREVENTER	2005	9,410	14	27.5	171	157	171	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,964,118	$ 188,938		$ 186,537	$ (2,401)	$ 1,432,718	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 352,888	$ 20,660	$ 52,280	$ 31,620	5-7YRS	$ 258,935	71
72	Current Year Purchases	13,493	2,698	1,349	(1,349)	5	1,349	72
73	Fully Depreciated Assets	226,208					226,208	73
74			16,777	16,777				74
75	TOTALS	$ 592,589	$ 40,135	$ 70,406	$ 30,271		$ 486,492	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT DEPT	1995 DODGE VAN	1994	$ 19,595	$	$	$		$	76
77	PETIENT TRANSP	1996 FORD WAGON	2000	21,907	1,262	2,191	929	5	21,907	77
78										78
79										79
80	TOTALS			$ 41,502	$ 1,262	$ 2,191	$ 929		$ 21,907	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,948,209	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 230,335	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 259,134	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 28,799	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,941,117	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 20,804 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19				0	19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 66,365	$		$ 66,365	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,125			6,125	2
3	Licensed Recreational Therapist	39-3	hrs							3
4	Licensed Physical Therapist	39-3	hrs			30,704			30,704	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				109,957		109,957	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	medical supplies & Other (specify): LABORATORY	39-2					38,722		38,722	13
14	TOTAL			$		$ 103,194	$ 148,679		$ 251,873	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 23,165)	1,007,246		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,980		6
7	Other Prepaid Expenses	18,273		7
8	Accounts Receivable (owners or related parties)	(291,018)		8
9	Other(specify): real estate tax escrow	158,584		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 948,065	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,009,893		15
16	Equipment, at Historical Cost	636,884		16
17	Accumulated Depreciation (book methods)	(813,157)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 833,620	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,781,685	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 450,504	$	26
27	Officer's Accounts Payable	832,090		27
28	Accounts Payable-Patient Deposits	27,050		28
29	Short-Term Notes Payable	714,985		29
30	Accrued Salaries Payable	74,201		30
31	Accrued Taxes Payable (excluding real estate taxes)	19,899		31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,374		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,185,103	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,185,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (403,418)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,781,685	$	48

***(See instructions.)**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (289,513)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (289,513)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,905)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (113,905)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (403,418)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,972,712	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,972,712	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	188,265	6
7	Oxygen	17,037	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 205,302	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,178,015	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,054,520	31
32	Health Care	1,780,635	32
33	General Administration	1,280,472	33
	B. Capital Expense		
34	Ownership	814,920	34
	C. Ancillary Expense		
35	Special Cost Centers	251,873	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,291,920	40
41	**Income before Income Taxes (line 30 minus line 40)****	(113,905)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (113,905)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	743	775	$ 21,972	$ 28.35	1
2	Assistant Director of Nursing	1,138	1,194	25,679	21.51	2
3	Registered Nurses	7,305	8,017	169,605	21.16	3
4	Licensed Practical Nurses	18,574	19,630	403,923	20.58	4
5	CNAs & Orderlies	72,283	74,776	695,742	9.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,168	2,954	77,821	26.34	8
9	Activity Director	977	1,175	9,518	8.10	9
10	Activity Assistants	5,350	5,643	40,452	7.17	10
11	Social Service Workers	5,764	6,334	83,107	13.12	11
12	Dietician					12
13	Food Service Supervisor	3,126	3,458	39,707	11.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,922	11,461	100,314	8.75	15
16	Dishwashers	8,016	8,344	59,038	7.08	16
17	Maintenance Workers	6,775	7,003	66,290	9.47	17
18	Housekeepers	20,370	21,402	168,259	7.86	18
19	Laundry	11,535	12,209	85,357	6.99	19
20	Administrator	1,339	1,428	38,777	27.15	20
21	Assistant Administrator	1,832	2,080	42,955	20.65	21
22	Other Administrative					22
23	Office Manager	4,008	4,264	46,558	10.92	23
24	Clerical	4,710	5,022	45,187	9.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: care plan coord	128	128	2,400	18.75	32
33	Other(specify) marketing	1,714	1,754	28,680	16.35	33
34	TOTAL (lines 1 - 33)	188,777	199,051	$ 2,251,341 *	$ 11.31	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 10,725	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant		1,755	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		14	10a-3	40
41	Occupational Therapy Consultant		9	10a-3	41
42	Respiratory Therapy Consultant		245	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		2,098	11-3	44
45	Social Service Consultant		3,020	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,866		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	698	$ 33,168	10-3	50
51	Licensed Practical Nurses	2,471	91,430	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	3,169	$ 124,598		53

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BETTY CADY	ADMIN		$ 5,829
AMY WEIR	ASST ADMIN		42,955
CYNTHIA TURNER	ADMIN		32,948
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,732

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 62,904
TOTAL (agree to Schedule V, line 17, col. 3)	$ 62,904
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		99,143
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 99,143

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 129,447
Unemployment Compensation Insurance		110,935
FICA Taxes		170,429
Employee Health Insurance		55,482
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,617
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		1,832
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		17,839
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 489,581

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,631
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	9,102
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,286
DUES & SUBSCRIPTIONS	67
MGMT CO ALLOCATION	85
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,192)
Yellow page advertising	(2,910)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,069

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	648
Seminar Expense	
	1,988
MGMT CO ALLOCATION	12,325
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,961

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number DANVILLE CARE CENTER # 0032862 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **109,500**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees